



ACGME

Accreditation Council for
Graduate Medical Education

2021 GME Stakeholders Congress

on Preparing Residents and Fellows
to Manage Pain and Substance Use Disorder

Documenting Two Days of Virtual Discussions

March 30 - 31, 2021

EXECUTIVE SUMMARY

The need to educate physicians on the management of pain and the recognition and treatment of substance use disorders (SUD), including Opioid Use Disorder (OUD), is a shared responsibility of medical schools and the graduate medical education (GME) and continuing medical education communities. To reach consensus on the curricular materials and experience needed for residents and fellows to acquire the skills and competencies necessary to effectively manage pain and recognize and treat SUD, the ACGME hosted a virtual GME Stakeholder Congress on Preparing Residents and Fellows to Manage Pain and SUD in March 2021.

Congress attendees developed recommendations for general and specialty-specific curriculum and educational experiences in support of a 2018 ACGME Common Program Requirement that mandates all programs “provide instruction and experience in pain management if applicable for the specialty including recognition of the signs of addiction.” (Common Program Requirement IV.C.2., effective July 1, 2019). The general recommendations featured three themes: multimodal pain management; an understanding of SUD and treatment; and communication with patients and the health care team.

Participants agreed that residents and fellows should learn evidence-based guidelines for recommending a multi-modal approach to pain using opioid, non-opioid, and non-pharmaceutical treatments. Residents and fellows should learn about proper opioid selection, dosage, duration, and tapering for situations when opioid analgesics are clinically indicated. Residents and fellows should also learn to assess whether a patient has or is at risk of developing an SUD, including OUD, and how to prescribe medication for OUD (MOUD) when necessary.

Residents and fellows should learn to talk with patients about the potential risks and realistic benefits of opioid analgesics and alternative therapies for pain, and to help patients set expectations for pain, function, and quality of life. They should be able to document and communicate a treatment plan to a patient’s care team, manage a hand-off, and work with an interdisciplinary care team.

Participants observed that bias and stigma toward pain and SUD, including OUD, as well as the medications used to treat OUD, negatively impact patients’ ability to receive appropriate care. Medications for OUD, such as methadone, buprenorphine, and naltrexone, remain underutilized, despite having been proven to increase treatment retention while decreasing illicit opioid use, among other benefits. These medications represent lifesaving treatment for

those struggling with OUD, making it critically important for residents and fellows to learn how to safely prescribe them or refer a patient with OUD for treatment.

Teaching residents and fellows to avoid using stigmatizing language (such as referring to patients as “addicts” or their urine drug tests as “clean” or “dirty”), will further help to establish an environment free of the stereotypes and biases that foster discrimination against those experiencing pain or SUD. Instilling these educational values in residents and fellows will require faculty members’ dedication to learning, teaching, and modeling these practices themselves.

The 10 specialties identified to participate in the Congress (anesthesia, emergency medicine, family medicine, internal medicine, obstetrics and gynecology, orthopaedics, pediatrics, physical medicine and rehabilitation, psychiatry, and surgery) are uniquely positioned to address resident/fellow knowledge gaps relating to pain and SUD. The specialty groups highlighted the differences between the contexts in which each provides care; however, several common themes emerged. All specialty groups called for residents and fellows to receive education and training in the multimodal management of acute and chronic pain; several also identified an understanding of the social determinants of health as they apply to providing culturally-literate or trauma-informed care; and the groups also supported the call to make existing resources pertaining to the development of a pain management and OUD curriculum widely available. Several groups identified their various specialty societies as a likely steward of this effort.

In sum, an effective curriculum in pain and SUD, including OUD, supports the development of physicians who are competent in pain management and can recognize and treat SUD. Residents and fellows should leave GME equipped with the skills necessary to communicate with patients and their families, and members of the interdisciplinary care team on these subjects. Finally, residents and fellows should learn that stigma and bias against those suffering from pain and OUD, as well as against the medications for OUD, prevent patients from receiving optimal care and should be eliminated from the clinical learning environment to the extent possible. While addressing the opioid epidemic through improved physician education and training will require institutions to invest in faculty development and infrastructure, the identification and use of existing resources related to pain and SUD, combined with meaningful collaboration across the continuum of medical education, provides a starting point for long-lasting change.

INTRODUCTION

In 2018, the Accreditation Council for Graduate Medical Education (ACGME) revised its Common Program Requirements to mandate that programs “provide instruction and experience in pain management, if applicable for the specialty, including recognition of the signs of addiction.” (ACGME Common Program Requirement, IV.C.2.) The ACGME made this change in response to the growing opioid epidemic that the US Department of Health and Human Services had recently declared a public health emergency. Since then, however, the number of deaths from opioid overdose has continued to rise, a trend further exacerbated by the COVID-19 pandemic and the devastating effects it has had on the mental health and well-being on large swaths of the population.

In addition to the ACGME’s response, in 2018 the National Academy of Medicine (NAM) convened its Action Collaborative on Countering the US Opioid Epidemic with the purpose of developing, curating, and disseminating multi-sector solutions designed to reduce opioid misuse and improve outcomes for individuals, families, and communities affected by the opioid crisis. The ACGME, one of several members of the Action Collaborative, has a representative who sits on the Collaborative’s Steering Committee and has two representatives along with a representative of the American Nurses Credentialing Center as co-leads of its Health Professional Education and Training Working Group. The Working Group is focused on creating a coordinated, interprofessional, and patient- and family-centered framework for the continuum of health professional education that addresses acute and chronic pain management and substance use.

The ACGME hosted the Graduate Medical Education Stakeholder Congress on Preparing Residents and Fellows to Manage Pain and Substance Use Disorder to further explore and develop more appropriate and extensive curricular resources and clinical experiences for resident and fellow education and training. NAM participated as a Planning Committee member of the Congress. The Congress gave leading practitioners from the major medical specialties, certifying boards, and societies, program directors, and ACGME Review Committee members the opportunity, through keynote presentations, panel discussions, and breakout deliberations, to tap into the expertise of leading physician members of the pain and addiction community and identify strategies to effectively prepare physicians to confront the challenges of recognizing and treating pain and opioid use disorder (OUD)¹. Congress participants also discussed and developed a list of key competencies that should be included in education and training for all residents and fellows, as well as competencies specific to learners in 10 specialties that play a role in treating pain and OUD: anesthesia; emergency medicine; family medicine; internal medicine; obstetrics and gynecology; orthopaedics; pediatrics; physical medicine and rehabilitation; psychiatry; and surgery.

¹The DSM-5 defines Opioid Use Disorder as a problematic pattern of opioid use leading to clinically significant impairment or distress. Opioid use is one of 10 categories of substances the DSM-5 considers part of Substance Use Disorder: Alcohol-related disorders, Caffeine-related disorders, Cannabis-related disorders, Hallucinogen-related disorders (including PCP and other drugs), Inhalant-related disorders, Opioid-related disorders, Sedative-, hypnotic-, and anxiolytic-related disorders (anxiety-related drugs), Stimulant-related disorders, Tobacco-related disorders, and Other substance-related disorders. American Psychiatric Association. The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition. This paper will focus on Opioid Use Disorder.

The Congress was held virtually March 30-31, 2021. Prior to the event, the ACGME prepared written materials, held virtual keynote presentations and panel discussions (accessed through the ACGME's online learning portal), and asked all participants to review those materials prior to attending the Congress. Representatives of national medical specialty societies and certifying boards, program directors, ACGME Review Committee members, and individuals representing the undergraduate to continuing medical education continuum were invited from a variety of systems and hospitals, diverse in size and geographic distribution, gender, race, and ethnicity.

The two-day Congress included question and answer sessions with keynote and panel speakers and Congress attendees, as well as breakout sessions to discuss key takeaways and develop general and specialty-specific recommendations on curriculum and educational experiences on the identification and treatment of pain and OUD. The material that follows includes a synopsis of these presentations, conversations, and recommendations, as well as the resources needed to implement the recommendations.²

BACKGROUND

The United States, with five percent of the world's population, accounts for 27 percent of the world's deaths from opioid use, highlighting the urgency of addressing the opioid epidemic. The COVID-19 pandemic has made a bad situation worse, with a 27 percent increase in opioid overdoses between August 2019 and August 2020. Less than a third of the individuals who experience OUD receive treatment, even though there are highly effective medications,³ including methadone, buprenorphine, and naltrexone.

Gaps in professional practice play an important role in the persistence of OUD among the US population. A literature review⁴ conducted by the NAM Action Collaborative on Countering the US Opioid Epidemic found professional practice gaps associated with prescribing or tapering opioids; screening, identifying, and diagnosing OUD; monitoring opioid analgesic use among patients; use of non-pharmacologic approaches to pain treatment; and prescribing medications other than opioids to treat pain or referring a patient for treatment for OUD. These gaps occurred in individual physicians, among health care professional teams, and in institutional policies.

²A compilation of the resources identified during the Congress by participants is included in Appendix A.

³Addiction—or compulsive drug use despite harmful consequences—is characterized by an inability to stop using a drug; failure to meet work, social, or family obligations; and sometimes (depending on the drug), tolerance and withdrawal. The latter reflect physical dependence in which the body adapts to the drug, requiring more of it to achieve a certain effect (tolerance) and eliciting drug-specific physical or mental symptoms if drug use is abruptly ceased (withdrawal). Physical dependence can happen with the chronic use of many drugs—including many prescription drugs, even if taken as instructed. Thus, physical dependence in and of itself does not constitute addiction, but it often accompanies addiction.

⁴Chappell, K., E. Holmboe, L. Poulin, S. Singer, E. Finkelman, and A. Salman, Editors. 2021. *Educating Together, Improving Together: Harmonizing Interprofessional Approaches to Address the Opioid Epidemic*. NAM Special Publication. Washington, DC: National Academy of Medicine.

Individual practice gaps included a lack of knowledge, experience, or strategies for prescribing non-opioids or non-pharmacologic approaches, such as physical and/or behavioral therapies, as well as provider fear of litigation related to opioid over-prescribing, diversion, and fraud, and the stigma, perceived or otherwise, of being a physician who specializes in addiction medicine.

For health care teams, a lack of interprofessional collaboration and a lack of interest in prescribing opioids among team members were the predominant practice gaps. Lack of interest in prescribing opioids, in turn, is driven in part by lack of self-efficacy and fear of abuse or litigation. Gaps in institutional policies included conflicts between organizational goals and those of providers and patients; insurance and reimbursement barriers that limit mental health services and referrals to addiction specialty care; and a lack of patient access to appropriate care or referral for pain and SUD treatment, particularly in rural areas.

The NAM Action Collaborative's Working Group also surveyed national, state, and other organizations regarding their educational requirements and found substantial variability among licensing, certification, and accreditation regarding pain and SUD management. Of the 62 organizations that responded to the survey, only 47 percent had requirements or standards for acute and chronic pain management, and only 31 percent had requirements or standards pertaining to SUD, with many accrediting organizations instead referring to state prescribing guidelines. This lack of concordance – lack of consistency among existing requirements and a lack of requirements where needed – may be among the greatest barriers to addressing the national opioid crisis.

INSIGHTS FROM THE KEYNOTE PRESENTATIONS

The Congress featured keynote presentations that addressed various aspects of opioid prescribing to treat acute or chronic pain. Daniel Alford, MD, MPH, professor of medicine, Boston University School of Medicine, presented on the standard of care for treating OUD and safer and more competent opioid prescribing for chronic pain, and discussed potential components of a baseline curriculum on these topics for residents and fellows. Travis Rieder, PhD, assistant director for Education Initiatives, Berman Institute of Bioethics, spoke about how his experience as a trauma patient can teach physicians about responsible pain medicine prescribing and treatment.

The keynote presentations reflected that, while it is true that opioid prescribing has decreased over the past several years, over-prescribing still occurs, in part resulting from insufficient education and training at all levels of the health professions regarding pain and OUD. Without sufficient education and training, physicians have low confidence in talking to patients about the potential risks and realistic benefits of opioid analgesics or about other therapeutic options and are not well-versed in assessing pain and managing pain therapy on an ongoing basis. As a result, there remains an over-reliance on opioids for treating acute and chronic pain and a lack of risk stratification regarding the risk of opioid misuse. In those situations where opioids are warranted, residents and fellows need instruction about appropriate opioid selection, dosage, and duration.

The key to appropriate initiation of opioid analgesics is a nuanced approach that balances the potential risks and realistic benefits to the patient for pain, function, and quality of life. Nuance is also important for the appropriate management of pain using both opioid and non-opioid medications and discontinuation of opioid analgesics. Management of pain with opioids should include regular check-ins with a patient's care team and monitoring for signs of misuse (e.g., loss of control, compulsive use, continued use despite harm). Residents and fellows should also learn strategies to mitigate risk, including co-prescribing naloxone, reviewing prescription drug monitoring program data, and using urine drug testing.

Multimodal Approaches to Pain

While opioids can be an important component of therapy for chronic, non-cancer pain, residents and fellows should be taught about multimodal approaches to pain management. There is compelling evidence that non-opioid and non-pharmacologic therapy should be the preferred first-line therapy for chronic pain, not opioids. Even when opioids are used, they should be combined with non-opioid and non-pharmacologic therapies and should only be continued if meaningful improvements of opioid use outweigh the potential risks of continued opioid dosing. Multimodal chronic pain treatment should include non-opioid medication, physical treatment, behavioral treatment, and interventional treatment (e.g., local pain injections) that together can reduce pain, restore function, improve quality of life, and cultivate well-being. Residents and fellows should learn to incorporate as many elements of this multimodal approach as possible for treating chronic pain.

Tapering

Regarding the discontinuation of opioid analgesics, the saying “you don’t fly a plane if you don’t know how to land it,” was stressed by Keynote Speaker Travis Rieder, PhD, and repeated by Congress attendees throughout the event. This statement reflected the sense that too many residents and fellows who go on to prescribe opioids do not learn the fundamentals of discontinuing opioid analgesics when there is too little benefit or evidence of harm. Too often, several participants noted, patients are left with little to no guidance on how to safely taper off opioids once their pain resolves or becomes manageable with non-opioid medications or other therapeutic approaches. Moreover, they have little idea on where to go for help when they experience symptoms of opioid withdrawal. In part, this issue has two root causes: a lack of education and training, and the lack of a physician in charge of creating, communicating, and overseeing a tapering plan. Better resident/fellow education in tapering is essential.

Communication

A critical need exists for residents and fellows to become skilled in talking with empathy to patients about their pain. Residents and fellows should learn to help patients set reasonable expectations for pain, function, and quality of life using opioid analgesics and alternative therapies for chronic pain, discuss the potential risks and realistic benefits of continued opioid use, explain the evidence behind other proven therapeutic options, and even make clear the medication they have prescribed is an opioid with attendant benefits and risks. Faculty members are essential in teaching, role modeling, and fostering skills in prescribing and recognizing the signs and symptoms of OUD and countering the stigma of opioid use; faculty development should be widely available to encourage and support best practices.

Medications for Opioid Use Disorder (MOUD)

Both Dr. Alford and Dr. Rieder discussed how the underuse of MOUD is in part the result of misunderstanding and stigma toward addiction, individuals with OUD, and the medications used to treat it. Teaching residents and fellows to address that misunderstanding and stigma, however, will require faculty members to be better educated about the robust evidence for addiction treatment. While there are three proven and approved medications for OUD—methadone, buprenorphine, and naltrexone—all are underused. Residents and fellows should learn about these lifesaving medications and how to prescribe them (e.g., buprenorphine, naltrexone) or refer for treatment (e.g., methadone) once an individual is diagnosed with an OUD.

Dr. Alford stressed that there is an extensive body of research demonstrating that medication for OUD increases treatment retention, employment, and improves birth outcomes while decreasing illicit opioid use, mortality, criminal activity, and the incidence of hepatitis and HIV seroconversion. Until recently, physicians required specific training to prescribe buprenorphine, but the federal government has enacted a new policy that allows any physician with a Drug Enforcement Administration prescriber license to obtain a waiver to treat up to 30 in-state patients with buprenorphine. Hospital-based physicians will be exempted from the 30-patient cap, and doctors can still treat up to 275 patients with the drug if they undergo eight hours of training. The hope is

that this policy change will lead to more widespread availability of buprenorphine therapy to those in need, given that only six-point-five percent of all physicians and 13.6 percent of primary care physicians chose to take the previously required training and obtain their X-waiver, and of those, only half use the training to care for patients.

Stigma

Both keynote speakers emphasized that the stigma surrounding pain and substance use can prevent patients from accessing appropriate pain care, or lifesaving treatment in the case of OUD. Dr. Rieder explained that physicians can either help dispel or reinforce the stigma associated with OUD through the language they use and by understanding the evidence demonstrating that OUD is a chronic, relapsing, yet treatable disease. Dr. Alford noted that this is demonstrated by DSM-5 criteria that no longer uses stigmatizing language, such as “dependent” or “abuse” and instead, classifies OUD as mild, moderate, or severe. Another example of destigmatizing language use is to teach residents and fellows to not refer to urine drug test results as “clean” or “dirty.” Shatterproof and the Centers for Disease Control (CDC)’s “Words Matter” website were two resources mentioned throughout the Congress that can help physicians learn destigmatizing language.⁵

Practice Gaps

In addition to a better understanding of the language and attitudes that perpetuate bias and stigma toward those struggling with OUD, Dr. Alford said there are several practice gaps that need to be addressed through education. These include:

- an over-reliance on opioids for managing acute and chronic pain;
- poor risk stratification of patients for the risk of opioid misuse before prescribing;
- low confidence in talking to patients about the potential risks and realistic benefits of opioid analgesics;
- poor assessment and documentation of the treatment plan and use of multimodal care during prescribing;
- a general lack of knowledge and use of universal precautions, such as monitoring for safety and adherence with urine drug testing and pill counting;
- a lack of skill in addressing worrisome opioid-taking behaviors;
- a lack of skill about knowing when to continue, modify, or discontinue opioids; and,
- a lack of skill in how to safely discontinue opioids.

⁵CDC. Words Matter: Preferred Language for Talking About Addiction. Available at www.drugabuse.gov/drug-topics/addiction-science/words-matter-preferred-language-talking-about-addiction. See also Shatterproof. Stigma-Reducing Language. Available at www.shatterproof.org/about-addiction/stigma/stigma-reducing-language.

Resources

While the presentations by both keynote speakers stressed the need for new curricular elements and faculty development to support nuanced initiation, management, and discontinuation of opioid analgesics, Dr. Alford also acknowledged that doing so will require resources that not all institutions possess, that not all program directors have the power or influence to enact, and that not all boards and Review Committees have the desire or competence to oversee. Addressing this issue will require advocating for financial support and system change so that all residents and fellows, regardless of where they complete their residencies and fellowships, have access to the appropriate educational resources and are afforded the opportunities to put their learning into practice in the clinic.

Dr. Alford discussed a successful approach in Massachusetts in which the state has taken steps to require its four medical schools to ensure graduates are properly trained on prevention and management of prescription drug misuse. Together, the schools developed competencies in the primary, secondary, and tertiary prevention domains needed to satisfy that edict. (See *Table 1*) Implementation challenges included a lack of oversight to ensure consistency in content, and to sustain, monitor, and update curricular efforts across the schools.

Table 1⁶

MEDICAL EDUCATION CORE COMPETENCIES FOR THE PREVENTION AND MANAGEMENT OF PRESCRIPTION DRUG MISUSE	
Domain	Task
Primary Prevention Domain - Preventing Prescription Drug Misuse Colon Screening, Evaluation, And Prevention	1.1: Pain assessment
	1.2: Screening & monitoring for SUD
	1.3: Treatment of acute & chronic pain
Secondary Prevention Domain - Treating Patients At-Risk For Substance Use Disorders: Engage Patient In Safe, Informed, And Patient-Centered Treatment Planning	2.1: Treating SUD
	2.2: Treating pain & SUD
	2.3: Patient counseling
Tertiary Prevention Domain - Managing Substance Use Disorders As A Chronic Disease: Illuminate Stigma And Build Awareness Of Social Determinants	3.1: Overdose education
	3.2: SUD as a chronic disease
	3.3: Stigma & biases
	3.4: Social determinants of health

Well-developed resources are available to assist residency and fellowship programs in developing curriculum in pain and OUD. Over 220,000 clinicians have received training through Boston University School of Medicine's "Safer/Competent Opioid Prescribing Education" (SCOPE of Pain) curriculum,⁷ which has proven effective at changing clinician behavior.

Summary

In summary, the keynote presentations enumerated the following key priorities for graduate medical education:

- minimum competencies for pain and OUD management, including instruction on initiating, monitoring, modifying, and tapering an opioid regimen, multimodal approaches to pain, and use of medication to treat OUD;
- commitment from educational institutions for further development and implementation;
- recognition and elimination of the stigma, stereotypes, and biases that foster discrimination against and interfere with appropriate treatment for those with pain and SUD; elimination of use of stigmatized language regarding pain, opioid use, and OUD;
- enhanced training on communicating with patients about opioid use; potential risks and realistic benefits of opioids and non-opioid or non-pharmacologic treatment methods for pain; and goals for pain, function, and quality of life;
- enhanced training on communicating with the patient care team;
- monitoring for signs of misuse (e.g., loss of control, compulsive use, continued use despite harm);
- identification and dissemination of priority professional practice gaps and better methods of tracking professional competencies; and,
- fostering of interprofessional collaboration among accrediting and certifying organizations.

⁶Antman KH, Berman HA, Flotte TR, et al. Developing core competencies for the prevention and management of prescription drug misuse: A medical education collaboration in Massachusetts. *Academic Medicine*. 2016;91(10):1348-51.

⁷Alford DP, Zisblatt L, Ng P, et al. SCOPE of Pain: An evaluation of an opioid Risk Evaluation and Mitigation Strategy continuing education program. *Pain Med*. 2016;17:52-63. Available at www.scopeofpain.org.

INSIGHTS FROM THE PANEL DISCUSSIONS

The Congress established four panels to discuss and answer questions from the perspectives of different groups of stakeholders. The panel discussions were recorded and available for online viewing prior to the Congress; during the Congress, panelists returned to field live questions from Congress participants. The four panels included representatives of the following stakeholders, discussing the following topics:

- **National medical specialty societies:** Standards of practice in pain management and the recognition and treatment of SUD
- **Certifying boards:** Assessment of competence in pain management and the recognition and treatment of SUD
- **Program directors:** Designing residency programs to include relevant education and experience in pain and SUD management
- **Review Committee members:** Assessment of program initiatives to incorporate relevant education and experience in pain and SUD management

The panels reaffirmed the keynotes' recommendations regarding communication, stigma, and faculty development. In addition, panelists recommended that curriculum and experience for residents and fellows in all specialties include:

- proper assessment of pain and potential risks for substance use-related harm;
- appropriate non-opioid and non-pharmacologic treatments for acute and chronic pain;
- the pharmacology of opioid and non-opioid pain medications;
- safer prescribing and management of opioids, including opioid selection, dosage and duration, tapering, and the assessment of which patients might be most susceptible to developing an OUD or substance use-related harms; and,
- screening for and recognition of SUD, and identification and referral of patients to any necessary ancillary services.

The panels repeatedly stressed the important role of interprofessional teams and teamwork in treating pain. Communication skills and proper hand-offs between team members should be included in the curriculum for all residents and fellows, through experiential learning and skills practice (e.g., role playing). The panels also observed that recent classes of learners are entering residency and/or fellowship having received some education and training in the treatment of pain and SUD. It is thus worth considering how to empower residents and fellows and integrate them into the educational process to improve models of education and training.

Effective communication encompasses listening to patients as part of assessing their pain, and counseling patients on the potential risks and realistic benefits of opioids on the evidence behind non-opioid and non-pharmacological approaches to pain, and establishing treatment goals. Residents and fellows also need to learn to communicate with their patients with empathy and cultural awareness, and without influence or conveyance of the stigma that can accompany SUD. The panel members considered motivational interviewing as an important competency for residents and fellows to develop.

Panelists said it is important for all residents, fellows, and faculty members to recognize and understand the stigma, stereotypes, and biases that patients experience, as well as the impact of these on patients' access to appropriate treatment. Residents and fellows must also learn that SUD are not moral failings, but rather chronic and relapsing brain disorders that can be treated.

At the same time, the panelists suggested that the specialty of addiction medicine suffers from stigma, in part because of a history of addiction treatment being separate from the traditional health care system, and in part because of the misperception that treating individuals with an SUD is futile. In fact, as several panelists noted, treating individuals with an SUD is highly rewarding and filled with more success than failure.

Panelists discussed the challenge of assessing some of the competencies those discussions deemed important. Written exams, for example, cannot effectively assess communication skills or teamwork, and yet assessing these competencies cannot just be boxes programs check. The panel members acknowledged that the type of narrative assessments that would be appropriate for such skills are hard to administer in large numbers. They also noted that certifying organizations and boards can set standards for competence in pain, SUD, and related areas that would drive both the adoption of new curricular elements and approaches for assessing such competencies.

BREAKOUT GROUP RECOMMENDATIONS ON CURRICULAR ELEMENTS

The keynote addresses and panel discussions served as the foundation for the Congress's primary purpose, which was to identify curricular elements and educational experiences that all residents and fellows should receive. Congress participants joined breakout rooms according to the specialty they represented of the 10 specialties invited to attend, and over the course of two hours, discussed specialty-specific curricular elements and experiences in the recognition and treatment of pain and addiction.

The narrative below is designed to provide the highlights of those discussions, noting the specific recommendations of competencies that all residents and fellows should master regardless of specialty, as well as tables listing the recommended competencies for each of the 10 specialties represented at the Congress. The participants in the breakout rooms were also asked to identify resources that would be needed to address new curricular requirements, and those are included for those groups that identified resources.

Curricular Elements for All Residents and Fellows

The breakout session discussions reaffirmed the curricular elements and educational experiences identified during the panel discussions for all residents and fellows. This section of the paper will not repeat those recommendations.

Recognition of the role that stigma plays in how pain and SUD are assessed and treated coupled with an understanding of implicit bias around pain and its impact on marginalized populations were identified as competencies for all residents and fellows. Other suggestions included developing a specific curriculum to address stigma that would include the differences among tolerance, physical dependence, as well as SUD and using pain and SUD treatment in case studies to teach communication to all residents and fellows.

Several groups noted the connection between SUD, stigma, and issues of diversity, equity, and inclusion. One suggestion to address issues related to access and health equity was to use telemedicine and remote monitoring to expand the reach of SUD treatment programs into underserved areas. Training on unconscious bias and cultural literacy were also suggested additions to the general residency curriculum. This would also include changing the language used to describe SUD and the patients who suffer from it.

There was considerable discussion in several of the breakout groups about the challenges that program directors may have dealing with adding competencies to the curriculum. In particular there was the concern that program directors would have a difficult time convincing faculty members of the need for change and managing the culture change required to introduce a new interprofessional, team-based pain treatment paradigm at many institutions. Many of the groups identified faculty development as a key component of addressing and replacing outdated and potentially harmful "hidden curricula" related to treating SUD.

RECOMMENDATIONS FOR CURRICULAR ELEMENTS AND EDUCATIONAL EXPERIENCES FOR ALL RESIDENTS/FELLOWS

Pain Management

- Multi-modal approaches to pain
- Non-opioid and non-pharmacologic treatment of acute and chronic pain
- Pharmacology of both opioid and non-opioid pain medications
- Safe opioid prescribing and management of opioid analgesics, including opioid selection, dosage and duration, and tapering
- Proper assessment of pain

Communication

- Value of interprofessional and interdisciplinary approaches to pain management
- Communicating effectively with team members and how to manage hand-offs
- Communicating with patients about opioid use; potential risks and realistic benefits of opioids and non-opioid or non-pharmacologic treatment methods for pain; setting reasonable goals for pain, function, and quality of life; and communicating with the patient's care team
- How to listen and talk to patients about pain and pain management
- Motivational interviewing
- Identifying and eliminating stigma, stereotypes, and bias that foster discrimination against and interfere with appropriate treatment for those with SUD
- Identifying and eliminating use of stigmatized language regarding pain and SUD

Substance Use Disorders (SUD) and Opioid Use Disorder (OUD)

- Use of medication to treat OUD
- Assessing individual patient risk for developing a SUD or substance use-related harms
- Understanding of SUD as brain disorders and not moral failings
- Recognition of SUD and where to refer patients for treatment
- Exposure to patients undergoing successful treatment for SUD

Specialty Recommendations

Anesthesiology

This breakout group noted that anesthesiologists see a broad range of patients that suffer from every aspect of pain, including trauma-related pain, medically-induced pain, and chronic pain. This unique position makes the ability to perform a thorough pre-operative evaluation and risk assessment an essential component of the curriculum for residents and fellows in anesthesia. The group noted that anesthesiology interfaces with every other specialty, providing an opportunity to have multispecialty educational experiences. An example would be learning to collaborate with surgical colleagues during the peri-operative period to identify risk factors for specific patients before commencing pain therapy (something, notably, the surgical breakout group suggested as well). Other specific recommendations were education in management of SUD in obstetric patients, exposure to the fundamentals of palliative care, and learning about the processes and psychological factors that can lead to SUD, perhaps with the support of faculty members in pain management and psychiatry. The group also suggested using quality improvement methods to introduce interventions, such as patient-specific opioid prescribing and tapering.

Anesthesiology Recommendations for Specialty-Specific Curricular Elements and Educational Experiences

- Identification of risk factors during the pre-operative assessment for specific patients at the commencement of pain therapy, and conveying that risk to the surgeons
- Assessment of pain and a patient's pain history
- Fundamentals of palliative care
- The process, symptoms, and psychology of addiction
- Management of SUD (from faculty members in pain management and psychiatry), including managing OUD in obstetric patients
- Laws and regulations regarding opioid prescribing
- Referral pathways for treatment of chronic pain or SUD
- Social determinants of health as they relate to chronic pain

Emergency Medicine

Participants in this group noted that emergency departments often serve as a safety net for those without the resources to otherwise receive care. Given that 70 to 80 percent of individuals who come to the emergency department experience pain among their symptoms, it is essential that emergency medicine residents receive more than superficial education and training in assessing pain, opioid selection, dosage, and duration, as well as non-opioid and non-pharmacological therapies to treat pain, screening patients for SUD, and referring patients with an SUD for treatment. This education and training should also include how to provide anticipatory guidance to patients on their pain and how medication should be used, as well as the potential risks involved. When linked to ongoing treatment in primary care, emergency department-initiated MOUD has been found to increase engagement in formal addiction treatment⁸. This link provides support for ensuring that residents and fellows can initiate MOUD treatment upon first contact in the emergency department in addition to being well-versed in making warm hand-offs for ongoing treatment. The group acknowledged that this would be difficult in rural and underserved urban and suburban areas with limited resources.

In terms of resources, hospitals should have a system-wide opioid stewardship committee to set safer prescribing guidelines for opioids. In addition, emergency department faculty members need more education and training on modeling desired opioid prescribing and the use of other alternatives to treat pain.

Emergency Medicine Recommendations for Specialty-Specific Curricular Elements and Educational Experiences

- Anticipatory guidance for safe opioid use
- Initiation of MOUD treatment when appropriate
- Collecting a family and personal history of opioid use and SUD
- Making hand-offs to community-based providers, including primary care and other office-based physicians, for specialized treatment

⁸D'Onofrio G, Chawarski MC, O'Connor PG, Pantalon MV, Busch SH, Owens PH, Hawk K, Bernstein SL, Fiellin DA. Emergency department-initiated buprenorphine for opioid dependence with continuation in primary care: outcomes during and after intervention. *Journal of General Internal Medicine*. 2017 Jun;32(6):660-6.

Family Medicine

This group noted that family medicine is the “medical home” for patient care and as such, family medicine residents and fellows should receive gatekeeper training for SUD, pain, withdrawal, and tapering, as well as education and training for prescribing buprenorphine, all in the context of chronic illness management. Specific subjects that family medicine residents should be taught include the pharmacology of opioids, physiology of acute pain, physiology of chronic pain, treatment of acute pain, and modalities beyond pharmacotherapy, as well as integration of behavioral health therapies where appropriate. Equally important is the need to offer ongoing technical assistance with these competencies so residents and fellows overcome anxiety associated with prescribing opioids or buprenorphine and become comfortable referring patients for medication for the treatment of OUD. Family medicine residents should receive more than superficial training in trauma-informed care and how to safely taper high-dose opioids in new patients.

Given the wide range of patients seen in the family medicine setting, a useful resource would be a culture-specific guide to addressing pain in the context of health inequities, one that included a collection of patient stories and vignettes. It would also be helpful to expose residents and fellows to public health and treating patients in a community setting. This breakout group noted the challenge of integrating their recommended competencies for family medicine residents and fellows into an already full program, especially in programs with limited resources.

Family Medicine Recommendations for Specialty-Specific Curricular Elements and Educational Experiences

- The pharmacology of opioids, physiology of acute pain, physiology of chronic pain, treatment of acute pain, and modalities beyond pharmacotherapy
 - How to treat or refer patients for treatment of OUD, including use of medications for OUD
 - How to integrate behavioral health therapies
 - Avenues for communicating with surgeons following pre-operative workup and assessment
 - Trauma-informed, culturally literate care
-

Internal Medicine

This breakout group had few specialty-specific competencies that it felt needed to be added to resident and fellow education and training other than additional instruction in the pharmacologic management and multimodal management of chronic pain. As residents and fellows may be asked to serve in an addiction medicine capacity, education and training should include an anti-stigma curriculum to treat patients with an SUD without bias, safer opioid prescribing, and how to refer patients for SUD treatment. The group recommended that residents and fellows get experience with motivational interviewing as a strategy to help patients better understand opioid analgesics and the potential for misuse.

This group also noted that while internal medicine is typically identified as a primary care specialty, only 20 percent of residents enter primary care, with the rest continuing to a subspecialty of internal medicine.

As sufficient resources exist on safer pain management, making referrals, and medications for treating OUD, efforts should be directed toward compiling those resources and making them widely available. This group specifically recommended that the ACGME should take charge of that effort.

A metric is needed to ensure that education and training approaches are working to make opioid prescribing safer. This group also noted that messages regarding safe opioid prescribing, stigma, and language use should be consistent across the undergraduate, graduate, and continuing medical education continuum. To that end, there should be a single source for concise information about how to best deliver these curricular topics in those three settings.

Internal Medicine Recommendations for Specialty-Specific Curricular Elements and Educational Experiences

- Management of chronic pain and SUD
- Approaches to help patients respond to and deal with despair, given that opioid overdose is a death of despair
- Instruction in stigma and bias
- Functional measures of pain that go beyond the simple 1-to-10 pain scale

Obstetrics and Gynecology

This group noted that obstetrics and gynecology covers the entire discipline of women's health, but the group's recommendation for curricular elements for residents and fellows in this obstetrics and gynecology all pertained to pregnancy. These included pain management for pregnant women, using widely available tools to identify patients who would be at risk of developing an SUD; identifying and managing acute withdrawal in pregnant women; and prescribing medications for OUD for pregnant women where clinically indicated. Residents and fellows should also understand the unique consequences of stigmatization on pregnant patients who may be reluctant to admit to struggling with SUD because of potential legal issues regarding custody of a child.

This group voiced the strong opinion that pain management in all its forms, except those related to pregnancy, should be an institution-wide and not specialty-specific competency. Rather than changing the Program Requirements for Obstetrics and Gynecology, institutions should find a way to enact a team-based approach to pain management across the institution. Such a curriculum should apply to anyone who prescribes pain medicine. The Clinical Learning Environment Review Program, an ACGME formative assessment activity, could be a vehicle for assessing an institution's success in providing education and training on safe prescribing, hand-offs, supervision, stigma, and bias.

Obstetrics and Gynecology Recommendations for Specialty-Specific Curricular Elements and Educational Experiences

- Pain management in pregnant women
 - Assessment of risk of a pregnant woman developing an OUD
 - Family-oriented approach to treating SUD in pregnant women
 - Recognition and management of acute withdrawal in pregnant women
 - Medication for pregnant women with OUD
 - Understanding the legal consequences associated with opioid use by pregnant women
-

Orthopaedics

The orthopaedic group concurred with the general recommendations regarding education on initiating and tapering opioids and multimodal pain management. For orthopaedic residents and fellows specifically, education in basic opioid pharmacokinetics, as well as SUD and opioids, was recommended.

All residents and fellows should learn how to manage pain for patients with pre-existing opioid tolerance or physical dependence, and how to recognize and distinguish between patients with tolerance, withdrawal, physical dependence, and OUD. To the latter point, education on the distinction between physical dependency and addiction and the appropriate interventions would be helpful.

While pain following orthopaedic surgery is often significant, common practices are to prescribe pain medicine based on the expected post-operative recovery time, with minimal counseling on whether and how to taper the opioid analgesics, or to prescribe medication to “hold a patient over” until another physician takes over the patient’s care. Teaching residents and fellows a more thoughtful and informed approach to these issues is warranted. Orthopaedic residents in particular need experience with pre-operative counseling to set patient expectations and address concerns.

Faculty support is needed to strengthen faculty members’ knowledge base regarding pain and SUD. The group felt the ACGME could provide resources and tools or highlight the many resources that already exist. The group recommended that the American Academy of Orthopaedic Surgeons develop Clinical Practice Guidelines (CPGs) for practice in appropriate prescribing and pain management, as the CPGs have a tremendous impact on education and practice. From there, the American Board of Orthopaedic Surgery can use the CPGs to develop questions and resources for initial and continuing certification.

Orthopaedics Recommendations for Specialty-Specific Curricular Elements and Educational Experiences

- Education in basic pharmacokinetics, OUD, and opioids
 - Education in the distinction between OUD and physical dependence, and related treatment options
 - Management of pain for patients with pre-existing opioid tolerance or physical dependence
 - Pre-operative counseling to address patient expectations and concerns
 - Faculty development
-

Pediatrics

The competencies that residents and fellows in pediatrics should master revolve around improved communication skills. Residents and fellows need to be able to counsel their patients and patients' parents about the potential risks and realistic benefits of opioids, and particularly about the expectations regarding pain relief associated with different therapeutic approaches, both pharmacologic and non-pharmacologic. Residents and fellows should also learn how to provide anticipatory guidance in common situations where opioids are prescribed, such as for treatment of sporting injuries for teens or wisdom teeth removal. Residents and fellows should also learn how to work with families in which there is an existing SUD, as well as methods to prevent both diversion and development of SUD.

Longitudinal curriculum on acute and chronic pediatric pain should be developed to support program directors, adapted from existing curriculum pertaining to adult patients. The pediatricians were confident the American Academy of Pediatrics could lead these educational efforts.

Pediatrics Recommendations for Specialty-Specific Curricular Elements and Educational Experiences

- Treatment of patients with chronic illness that involve pain
 - How to work with families in which there is an OUD or SUD
 - Anticipatory guidance for common situations where opioids are prescribed
 - Hand-offs between urgent care and primary care or inpatient and outpatient settings
 - Longitudinal curriculum on acute and chronic pediatric pain, adapted from existing curriculum pertaining to adult patients
-

Physical Medicine and Rehabilitation

As the third largest prescriber of opioids, residents and fellows in physical medicine and rehabilitation should master competencies regarding the different therapeutic options for treating acute and chronic pain, including non-opioid and non-pharmacologic therapies. This group recommended that residents and fellows need to acquire pain-related competence related to systems-based practice, interpersonal and communication skills, patient care, and professionalism; be able to screen for substance use; recognize intoxication and withdrawal symptoms; know how to taper patients off opioids; and understand the epidemiology of chronic pain. This group also recommended that residents and fellows be trained in naloxone prescribing and overdose and rescue treatment.

The group noted the need to educate physical medicine and rehabilitation program directors that rotations can be with non-physiatrists, such as anesthesiologists or experts in pain and SUD. Physical medicine and rehabilitation residents and fellows should have access to resources such as an addiction consultant or rotation experience. The physiatrists planned to contact the American Academy of Physical Medicine and Rehabilitation to create resources and educational materials to support learning in these areas.

Physiatry Recommendations for Specialty-Specific Curricular Elements and Educational Experiences

- Systems-based competencies regarding communication with other care team members, patient care, and professionalism
- Epidemiology of pain
- Overdose and rescue therapy
- Interventional pain therapies
- Opioid conversion

Psychiatry

This breakout group discussed that, while treatment of pain is not a core part of psychiatrists' practice, residents and fellows should learn about the psychological and neurological components of pain, the difference between acute and chronic pain, and how to use cognitive behavioral therapy for managing pain. Residents and fellows should gain an understanding that chronic pain issues are often comorbid with psychiatric disorders. In that respect, residents and fellows should learn how to discuss with patients why management of mental health conditions is an important component of pain management, and to discuss how pain impacts or has impacted their life and goals.

Psychiatry residents and fellows need broader education and training about treatment for addiction, particularly regarding the pharmacological basis of pain therapy. In addition, residents and fellows should understand the underpinnings of addiction, including addiction related to pain or social determinants of health. They should learn about the demographics of usage within their communities and the cultural associations with substance use, and should be familiar with the non-medical support system in the community.

Psychiatry residents and fellows should become comfortable prescribing methadone, buprenorphine, naltrexone, and other medications for OUD, just as they learn to prescribe controlled substances such as stimulants for ADHD or benzodiazepines or other drugs for anxiety and insomnia. As such, they should be able to:

- conduct a risk assessment for prescribing controlled substances;
- take a history of what substances a patient has used;
- assess what comorbid mental health conditions a patient has, as well as childhood trauma and Adverse Childhood Experiences risk;
- monitor and interpret urine drug tests; and,
- understand when and where to refer for additional treatment for addiction.

The group suggested that the need for an X-waiver contributed to the stigma of addiction and prescribing of buprenorphine, and that such prescribing should be an accepted part of psychiatrists' practice. At the same time, residents and fellows should learn about non-opioid pain management. The group also felt psychiatrists should be prepared to prevent, diagnose, and manage symptoms of withdrawal in both the inpatient and outpatient settings, and understand guidelines on tapering.

Resources are needed for program directors, particularly those who are new or in rural programs, small institutions, or community settings. A systemic approach to faculty development is needed as well. Important resources referenced include risk tools for controlled substances, access to medically supervised withdrawal treatment facilities (i.e., detoxification) and sobriety groups, and extensive clinical practice in treating SUD in a variety of settings for both acute and chronic pain.

One participant recommended a paper providing a model of how to recognize addiction learning opportunities already present in the general education and training environment, and development of successful educational experiences to maximize such opportunities.⁹

One suggestion this group strongly supported was to have all residents and fellows, throughout the course of their residency or fellowship, follow one individual undergoing treatment for an SUD, a chronic disease that may not always follow a linear path. Doing so should help them better understand the role stigma plays as well as the value of treatment. The group also recommended establishing learning cooperatives for faculty development.

Psychiatry Recommendations for Specialty-Specific Curricular Elements and Educational Experiences

- Education on the neurological, psychological, and social aspects to pain
- Cognitive behavioral therapy for managing pain
- Understanding why chronic pain is often comorbid with psychiatric disorders
- Communicating with patients about treatment options and why management of mental health is important for pain management
- How to access and refer patients to non-medical support systems within the local community, such as support groups
- Relationship between pain and the social determinants of health, particularly in the residents'/fellows' community
- For those residents and fellows who want to become trained in addiction psychiatry:
 - › Conducting a general pain assessment
 - › Recommend treatment options to the pain care team
 - › Conducting a risk-benefit profile regarding substance use disorder
 - › Clinical practice in treating SUD in a variety of settings for acute and chronic pain

⁹Addiction Teaching and Training in the General Psychiatry Setting

Surgery

The surgeons observed that they are often the first to see patients who present with SUD, who are at risk of SUD, or who have problems stemming from SUD that require surgical care. They also recognized they often initiate opioid therapies.

While surgical residents and fellows should know how to taper a patient off opioids, this is often not their responsibility, and so it may be more impactful to master appropriate or tailored opioid selection, dosing, and duration. Surgical residents and fellows should develop competence in non-opioid and non-pharmacologic alternatives to opioids for safer and more effective peri- and post-operative pain management, such as the use of regional pain approaches and preemptive blocks for treating pain. The group felt their anesthesiology colleagues would be valuable partners in helping to educate surgical residents and fellows on these approaches to pain management.

Noting that SUD can impact surgical outcomes, residents and fellows should learn how to screen patients for SUD or risk factors for developing an SUD using approaches such as the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration's (SAMSHA) Screening, Brief Intervention, and Referral to Treatment (SBIRT)¹⁰ approach.

Surgical residents and fellows should receive education on documenting and communicating a pain plan with patients, patients' families, and patients' care teams. They should learn when to order a psychiatric consult for comorbid depression or other serious mental health conditions, as well as how to hand off patients to their primary care physician. Surgical residents and fellows could also benefit from exposure to osteopathic manipulative therapy and complementary medicine approaches to treating pain, particularly muscle discomfort.

¹⁰U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Screening, Brief Intervention, and Referral to Treatment (SBIRT). www.samhsa.gov/sbirt.

Surgery Recommendations for Specialty-Specific Curricular Elements and Educational Experiences

- Use of alternatives to opioids for safe and effective peri- and post-operative pain management, such as the use of regional pain approaches, preemptive nerve blocks, infusion pumps, and other approaches to treat or manage pain
 - Peri- and post-operative pain protocols
 - Screening for substance use or risk factors for substance use
 - Awareness about resources to utilize for consultations or referrals for patients who require treatment or support for SUD or co-occurring conditions, such as a mental health condition
 - Understanding when to refer to primary care, psychiatry, and/or social work
 - Communicating a pain plan to the patient and the patient's caregivers
 - Documenting and communicating a pain plan to the patient's primary care physician
 - Understanding when to refer to osteopathic manipulation, chiropractic, massage, or acupuncture therapy for muscle pain
-

RESOURCES FOR MANAGING PAIN AND SUBSTANCE USE DISORDER

The following resources were identified during Congress presentation and discussions as for those seeking to develop a curriculum in pain management and substance use disorder.

Resources Highlighted During Keynote Addresses

BUSM “Scope of Pain” course

A two-hour FDA/opioid REMS compliant SCOPE of Pain program that includes an online program, live webinars, and a podcast, as well as:

- [Micro-case](#) audios
- A [Trainers Toolkit](#) that includes: a case study with discussion questions, video vignettes, skills-practice exercise, PowerPoint with embedded videos and discussion questions and supplemental safe opioid prescribing modules
- [Supplemental Training](#) for trainees focused on surgical, emergency medicine, or adolescent specialties.

Bias and Stigma

Combating the Opioid Crisis: Addressing the Stigma – Public Health Foundation

The Public Health Foundation (PHF), a private, non-profit, 501(c)3 organization, improves public health and population health practice to support healthier communities.

- TRAIN Learning Network provides timely training on hot topics such as [opioids](#), emergency preparedness and response, infectious diseases, and immunization.
- Continuing education credits such as CNE, CME, CEU/CE, CHES, and many others.
- This webcast “provides an overview of how stigma negatively affects people who use drugs (PWUD) and provides strategies for reducing stigma as key strategy for addressing the opioid crisis.”

Reducing Stigma Education Tools (ReSET): Dismantling the Stigma of Opioid Use Disorder through Asynchronous Interprofessional and Interactive Online Education

This [interactive and evidence-based educational platform](#) includes original video content of people with lived experience who are in recovery, incorporates learning check points, and was designed by University of Texas researchers with expertise in health communication. The 90-minute curriculum includes important topics such as the origin of stigma, impact of drug policy on stigma, and clinical applications of how stigma reduces access to care.

Reducing Stigma Education Tools (ReSET)

The aim of these modules from the Dell Medical School is to help clinicians [identify and address stigma surrounding opioid use disorder](#), to ensure the delivery of equitable and compassionate health care for all patients living with substance use disorder.

Stigma-Reducing Language

Federal guidance for using [“person-first”](#) language when discussing substance use disorder.

Organizations

National Institute on Drug Abuse (NIDA)

The mission of NIDA is to “advance science on the causes and consequences of drug use and addiction and to apply that knowledge [to improve individual and public health.](#)”

- [NIDA Screening and Assessment Tools Chart](#)
 - A chart of over 20 online screening tools designed to assess a patient’s risk for substance misuse and substance use disorder and assist the clinicians with prevention and treatment strategies.
 - Different options indicating when a specific screening tool is used depending on substance type, patient age, and how tool is administered
- NIDA Drug Screening Tool – [NIDA-Modified ASSIST](#)
 - This tool guides clinicians through a series of questions to identify risky substance use in their adult patients.
 - The resources assist clinicians in providing patient feedback and arranging for specialty care, where necessary

American Society of Addiction Medicine

A professional society dedicated to [improving the quality of addiction treatment](#), educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction.

Aunt Bertha Social Care Network

Connects people seeking help and [verified social care professionals](#) that serve them.

Substance Abuse and Mental Health Services Administration (SAMHSA)

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to

advance the behavioral health of the nation. SAMHSA's mission is to [reduce the impact of substance abuse and mental illness](#) on America's communities.

Providers Clinical Support System (PCSS)

(See also [PCSS-NOW](#)) A program created in response to the opioid overdose epidemic to train primary care professionals in the [evidence-based prevention and treatment of opioid use disorders \(OUD\) and treatment of chronic pain](#). The project is geared toward primary care professionals who wish to treat OUD. PCSS is made up of a coalition, led by American Academy of Addiction Psychiatry (AAAP), of major healthcare organizations all dedicated to addressing this healthcare crisis. Through a variety of trainings and a clinical mentoring program, PCSS's mission is to increase clinicians' knowledge and skills in the prevention, identification, and treatment of substance use disorders with a focus on opioid use disorders.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

A comprehensive, integrated, public health approach to the delivery of early [intervention and treatment services for persons with substance use disorders](#), as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

Opioid Response Network

SAMHSA identifies individuals with training and experience in the community to help clinicians address [prevention, treatment and recovery](#) needs and facilitate access to evidence-based resources. The network provides local training and education free of charge for specific needs at a community level.

National Addiction Technology and Transfer Center (ATTC)

An international, multidisciplinary resource for professionals in the [addiction treatment and recovery services field](#).

The ATTC Mission and Values are to:

- Accelerate the adoption and implementation of evidence-based and promising addiction treatment and recovery-oriented practices and services;
- Heighten the awareness, knowledge, and skills of the workforce that addresses the needs of people with substance use or other behavioral health disorders; and
- Foster regional and national alliances among culturally diverse practitioners, researchers, policy makers, funders, and the recovery community.

Pain Assessment and Measurement

NASEM Consensus Study Report - Framing Opioid Prescribing Guidelines for Acute Pain

- Evaluates existing [clinical practice guidelines](#) for prescribing opioids for acute pain indications
- Recommends indications for which new evidence-based guidelines should be developed
- Recommends a future research agenda to inform and enable specialty organizations to develop and disseminate evidence-based clinical practice guidelines for prescribing opioids to treat acute pain indications

Providers Clinical Support System (PCSS) - O Core Curriculum Module 5

PCSS provides “evidence-based training and resources to give healthcare providers the skills and knowledge they need to treat patients with OUD.”

Educational objectives of this [module](#):

- Describe universal precautions and their role in opioid therapy
- Review monitoring and documentation strategies for opioid therapy
- Explain the fundamental principles of urine drug testing and interpretation
- List the differential diagnosis for aberrant drug related behavior

Non-Pharmacologic Approaches

US Department of Veterans Affairs – Opioid Safety

Addresses the VA/Department of Defense [clinical practice guidelines](#) for managing chronic pain, as well as the latest resources for clinician education, patients/veteran's information, and other resources. The VA's Opioid Safety Initiative and Toolkit includes various documents and presentations for clinicians to aid in decisions about starting, continuing, or tapering opioid therapy, and other challenges related to safe opioid prescribing.

AHRQ - Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review

This review provides [alternative strategies](#) to chronic pain care.

Camden Coalition of Healthcare Providers

Lessons from pharmacists about [opioid overdose prevention efforts](#). The Camden Coalition works to advance the field of complex care by implementing person-centered programs and piloting new models that address chronic illness and social barriers to health and wellbeing.

Research/Summits

AAMC MedEd Portal Collection of Resources on Opioids

The objectives of this [collection](#) are:

- To highlight examples of how pain management, addiction medicine, and opioid curricula can be integrated as a standard practice of care in medical education, clerkships, residencies, and hospital/clinic practice.
- To provide deans, faculty, staff, and other institutional leaders with tangible, practice-based, peer-reviewed resources for improving practice in pain management, addiction medicine, and opiate education.
- To recognize faculty developers for their educational scholarship in pain management, addiction medicine, and opioid education.
- To foster collaboration and research pain management, addiction medicine, and opioid education.

American Society of Anesthesiologists (ASA) Virtual Pain Summit

The American Society of Anesthesiologists (ASA) hosted [a virtual pain summit](#) on February 20, 2021 with 14 medical specialty societies to discuss acute surgical pain principles that will serve as the basis for a multi-society acute pain resource. The first-of-its-kind event brought together a group of representing the major surgical stakeholders in acute pain management with the goal of reaching consensus on important principles regarding the treatment of perioperative pain. These principles will be developed into a guiding resource for clinicians and all members of the surgical care team in 2021.

An international multidisciplinary consensus statement on the prevention of opioid-related harm in adult surgical patients

Levy, N., Quinlan, J., El-Boghdadly, K., Fawcett, W.J., Agarwal, V., Bastable, R.B., Cox, F.J., de Boer, H.D., Dowdy, S.C., Hattingh, K., Knaggs, R.D., Mariano, E.R., Pelosi, P., Scott, M.J., Lobo, D.N. and Macintyre, P.E. (2021), An international multidisciplinary consensus statement on the prevention of opioid-related harm in adult surgical patients. *Anaesthesia*, 76: 520-536. <https://doi.org/10.1111/anae.15262>

Transitions of Care for Postoperative Opioid Prescribing in Previously Opioid-Naïve Patients in the USA: A Retrospective Review

Klueh, M. P., Hu, H. M., Howard, R. A., Vu, J. V., Harbaugh, C. M., Lagisetty, P. A., Brummett, C. M., Englesbe, M. J., Waljee, J. F., & Lee, J. S. (2018). Transitions of Care for Postoperative Opioid Prescribing in Previously Opioid-Naïve Patients in the USA: a Retrospective Review. *Journal of general internal medicine*, 33(10), 1685–1691. <https://doi.org/10.1007/s11606-018-4463-1>

Tool Kits/Practice Guidelines

AMERSA Core Competencies – Specific Disciplines Addressing Substance Use: AMERSA in the 21st Century

This serves as a multidisciplinary update to the Mainstream core competencies which were published by AMERSA in 2002. [The 2018 Update](#) is a practical document consisting of five brief discipline-specific (medicine, nursing, pharmacy, social work, physician assistants) chapters, corresponding core competencies for professionals to identify and address substance use problems and disorders, including opioid use disorders, and a comprehensive bibliography. The document provides updated guidance to health professionals, and provides a roadmap of knowledge, skills, and attitudes recommended for health professional trainees to support them in effectively assessing and treating patients who use alcohol and other drugs.

American College of Obstetricians and Gynecologists-Opioid Use Disorder in Pregnancy Resources

This toolkit includes resources on [managing opioid use disorder in during pregnancy](#) including prevention and recognition as well as other clinical guidance and resources such as a podcast series.

American College of Physicians Chronic Pain and Safe Opioid Preserving Resources

Resources provided through this program are designed to assist with understanding quality improvement and practice transformation methodology as well as evidence-based strategies for [effective management of chronic pain in primary care](#), including assessment and management of psychological comorbidities and identify resources for prevention, treatment, and recovery of opioid use disorder

Anesthesia Toolbox- Preop Online Module 3: Substance Use Disorder and Preoperative Management

The learning objectives of the [module](#) include defining addiction and substance use disorder, recognizing various co-morbid conditions associated with substance abuse and their perioperative implications, comparing and contrasting several options for preoperative management of medications used to treat substance use disorders and describing the utility of standard urine drug testing.

End the Epidemic (An initiative of the American Medical Association)

The AMA Opioid Task Force consists of over 25 national, specialty and state medical associations committed to providing [evidence-based recommendations and leadership](#) to help end the opioid epidemic.

The Joint Commission-Pain Assessment and Management Standards

The Joint Commission pain and management standards [outline a multi-level approach to pain management](#) to help clinicians deliver safe pain care.

Online Courses/Curricula

Addiction Treatment: Clinical Skills for Healthcare Providers (online course)

This course is designed with a singular goal: [to improve care for patients with substance use disorders](#). Instructors from various fields provide techniques to screen your patients for substance use disorder risk, diagnose patients to gauge the severity of their use, directly manage treatment plans, refer out to treatment services, and navigate the various conditions that may limit patient access to treatment.

National Neuroscience Curriculum Initiative (NNCI)

The NNCI is a collaboration between educators and neuroscientists. The overarching aim of the NNCI is to create, pilot, and disseminate [a comprehensive set of shared resources](#) that will help train psychiatrists and other mental health professionals to integrate a modern neuroscience perspective into every facet of their clinical work.

Prescriber Education Core Competencies (Massachusetts)

Cross-institutional core competencies for [the prevention and management of prescription drug misuse](#) that will reach the approximately 3,000 enrolled medical students across the Commonwealth of Massachusetts.

Other Resources

AAMC Opioid Education Challenge Grant Program

As part of the AAMC's effort to assist its members' work to counter this epidemic, nine institutions or partnering institutions were selected to receive [grants](#) to develop tools and resources to support educators in their collaborative efforts to increase faculty proficiency in the areas of pain management, opioid use disorder (OUD), substance use disorders (SUD), medication-assisted treatment (MAT), safe prescribing practices, and addressing stigma.

CME for FDA Risk Evaluation and Mitigation Strategies (REMS)

The [FDA Risk Evaluation and Mitigation Strategy \(REMS\)](#) for opioids leverages accredited continuing education to address the opioid crisis. This site contains resources for clinicians who choose to design education to fulfill the REMS goals.